

REC'D JAN 24 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1866  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Cape Girardeau Registration District No. 1205  
 (b) Township Cape Girardeau Primary Registration District No. 3009  
 (c) City Cape Girardeau Street No. St. Francis Hospital Registered No. 27  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 535 FENNIE LINTON.  
 (a) Residence, No. ILLMO MO. St.  Illmo, Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joe Linton.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Febr 11th 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
42 11 5

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House keeper  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott Couty Mo.

FATHER  
 13. NAME Zeno. Higgins.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER  
 15. MAIDEN NAME Nancy Craddock.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Della Scherer ( Sister )  
Benton. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pollard cemetary DATE Jan 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) T.S. Heisserer and  
Oran Mo.

20. FILED 1-16 1939 J.M. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 16th 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/12/39, 1939, to 1/16/39, 1939.  
 I last saw her alive on 1/16/39, 1939. Death is said to have occurred on the date stated above, at 9:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Myocarditis  
hypertension  
Influenza

Other contributory causes of importance:  
none

Name of operation none Date of none  
 What test confirmed diagnosis? Urinary Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury none, 1939  
 Where did injury occur? none  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none  
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased?  
no, specify no  
 (Signed) Dr. Lee, M. D.  
 (Address) Illmo Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ven.

1320

CCJ BYLION is a proud state  
Excelsior Inc

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1866  
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3009 Registered No. \_\_\_\_\_  
 (c) City Cape Gir (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Fennie Linton  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED DW  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 16 1919

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
42 11 5

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

myocarditis  
 Date of onset 12/1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
Nephritis - Influenza  
Chronic

13. NAME

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

Manner of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury \_\_\_\_\_

20. FILED \_\_\_\_\_ 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) A. E. Lee, M. D.

(Address) St. Louis Mo.

Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

EXACT STATEMENT OF OCCUPATION IS VITAL.

S-1866